House of Commons

Science and Technology Committee

Clinical trials: Health Research Authority Response to the Committee's Third Report of Session 2013–14

Fifth Special Report of Session 2013–14

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Science and Technology Committee

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The Reports of the Committee, the formal minutes relating to that report, oral evidence taken and some or all written evidence are available in printed volume(s). Additional written evidence may be published on the internet only.

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Fourth Special Report

On 17 September 2013 the Science and Technology Committee published its Third Report of Session 2013–14, *Clinical trials* [HC 104]. On 4 October 2013 the Committee received a memorandum from the Health Research Authority which contained a response to the Report. The memorandum is published as Appendix 1 to the Report.

Appendix 1: Health Research Authority response

The Health Research Authority (HRA) welcomes the publication of the House of Commons Science and Technology Committee report into Clinical Trials and the recognition of the HRA's role. We have already taken steps in the many of the areas identified by the Committee to improve awareness, promote transparency and improve efficiency in the regulation of health research in the UK.

This document provides the HRA's response to the recommendations. We are aware the Government will also respond to the report.

Response to Conclusions and Recommendations

What are clinical trials?

1. Clarity in use of the term "clinical trial" is essential. The establishment of consistent terminology would be an important first step towards making the UK an easier place to conduct clinical research. We recommend that the Government agrees a set of simple definitions for the terms "clinical trial", "clinical study" and "clinical research" and ensures their consistent use across the Health Research Authority, Medicines and Healthcare Products Regulatory Agency, Medical Research Council, National Institute of Health Research and the NHS. (Paragraph 11)

The HRA has defined clinical trials, with IRAS partners, using categories in the Integrated Research Application System (IRAS). We will continue to promote and support activities that provide clarity and consistency in terminology associated with health research.

UK regulatory and governance complexity

3. We commend the establishment of the Health Research Authority (HRA) and note that feedback on the HRA's performance to date has been largely positive. However, we are unable to judge whether the HRA has so far been effective in achieving its objectives, as the necessary performance indicators are not currently in place. We recommend that the HRA establishes and publishes a suite of relevant key performance metrics and targets in its 2014/15 Business Plan, and monitors performance against these targets annually. We further recommend that a triennial review of the HRA takes

place no later than December 2014, three years after its creation as a Strategic Health Authority. (Paragraph 31)

The HRA has provided metrics in all its business plans for its current objectives.[1] These include the performance of HRA Research Ethics Committees (RECs) which are a key part of the overall regulation and governance of research in the UK. The timelines for the Gene Therapy Advisory Committee (GTAC) have shown significant improvement under HRA management. More information on our metrics is available on our new website.[2] HRA RECs continue to deliver well within the statutory 60 days and the proportionate review service delivers impressive timelines for low-risk studies. We recognise that more work is needed to refine these, particularly for the HRA projects that will streamline the research pathway. We are working with others to ensure those metrics are as widely supported as possible and capture the full research journey for health research in the UK.

As a public body we welcome being held to account.

4. Over a year after its creation, some stakeholders (including an academic health science centre, intended to be a centre of excellence for UK health research) remained unaware of the function, or even the existence, of the HRA. Although these stakeholders also bear some responsibility for their own awareness of such developments, we consider that the HRA should now place greater emphasis on engaging with the clinical research community and raising the profile of its work. The HRA should detail in its response to this Report how it intends to do this. (Paragraph 32)

The HRA's communications function was reviewed in its first communications strategy in 2012. Whilst the HRA and its predecessor organisation had a communications function, dedicated resources to implement the new strategy were agreed formally in 2013. The strategy has a number of objectives including engaging with the health research community, and patients and the public.

Our planning for delivering the communications strategy began in January 2013—when the Committee took evidence—and its implementation is now well underway, including our now published patient and public dialogue. We recognise that the changing NHS and regulatory landscape may have meant that some were not yet aware of the HRA, although the National Research Ethics Service is a core HRA function which has been widely recognised as transforming the research ethics service in the UK.

As well as holding meetings with key stakeholders, including our first annual stakeholder event in February 2013, we published the HRA's first Annual Review in May;[3] and issued three editions of a bi-monthly newsletter (HRA News), now read by 1300 subscribers, and communicated onwards by the National Institute for Health Research (NIHR) and NHS R&D Forum. We have published 26 news stories (as of 16 September 2013), many of which have received coverage in the specialist research press, and been communicated through social media by high profile individuals with large numbers of followers. A new HRA

[1] http://www.hra.nhs.uk/documents/2013/09/hra-business-plan-2013-2014.pdf#page=17

[2] http://www.hra.nhs.uk/about-the-hra/governance/our-performance/

[3] http://www.hra.nhs.uk/documents/2013/10/annual-review-2012-2013.pdf

website will be launched on 7 October 2013. We also gave evidence this year to two other Parliamentary Committees:

- The Joint Committee on the draft Care and Support Bill (now Care Bill).[4] Evidence session available here.[5]
- The House of Lords Science and Technology Committee Inquiry into Regenerative Medicine.[6] The Government response has recently been published.[7]

We will use the information from the House of Commons Science and Technology Committee Report on Clinical Trials to refine the elements of the Communications Strategy that relate to the health research community. We have established programmes of meetings with key organisations but we are aware of the need to engage more widely and in an even more targeted way. We note that there are same academic organisations linked to Academic Health Science Centres who have a high level of engagement (for example 45 subscribers from the University College London alone). We plan to review our relationships systematically to ensure we have an even better balance across all or networks. In the meantime, we encourage Academic Health Science Networks , if not already done so, to sign up to our communications.

The HRA's communications strategy and plan are subject to review by the HRA Board and are currently subject to an independent advisory audit.

5. We welcome moves by the HRA to streamline NHS governance arrangements and stress the importance of this initiative, which, in our view, should be given the highest priority. Following completion of the feasibility study, we recommend that a timeline detailing the next steps be published as part of the HRA's response to this Report. The Government should assist the HRA in its efforts to meet this priority, including making additional resources available if necessary. (Paragraph 35)

We very much welcome the support for the HRA's work to streamline research approvals in the NHS, and have submitted plans to our Board for further consideration. This includes the assessment of additional resources required to deliver this work to streamline both R&D and REC approval into a single HRA assessment and approval. To implement this work we will need to work with key partners including NHS R&D and the NIHR. Information on this and other work we are doing to improve the research journey is available in issue 3 of the HRA newsletter.[8] The timelines are: a confidential HRA Board discussion on 25 September 2013, then submission and discussion with DH in mid-October. The proposals look at options for implementation, and cost-effectiveness. One key advantage of a single approval process will be greater simplicity and opportunity to measure metrics from a common starting point for approval—HRA validation. The plans will be published once agreed.

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[4] http://www.parliament.uk/business/committees/committees-a-z/joint-select/draft-care-and-support-bill/publications/

[5] http://www.parliamentlive.tv/Main/Player.aspx?meetingId=12460

[6] http://www.parliament.uk/business/committees/committees-a-z/lords-select/science-and-technology-committee/news/regen-med-report-published/

[7] https://www.gov.uk/government/publications/regenerative-medicine-inquiry-government-response

[8] http://www.hra.nhs.uk/documents/2013/09/hra-latest-volume-3.pdf

Patient recruitment

8. We note the apparent lack of public confidence in the pharmaceutical industry and are concerned that this may increasingly pose a barrier to conducting trials in the NHS. Industry should act to regain trust lost through past examples of poor behaviour by engaging more effectively and transparently with the public in the future. In addition, Trusts need to do far more to educate patients about the benefits, both to them and to the wider community, of participating in research and allowing properly controlled sharing of patient data. (Paragraph 44)

As noted in the House of Commons Science and Technology Committee Report on Clinical Trials, the HRA's work with Ipsos MORI showed the public have a high level of trust in research undertaken by the NHS, but had less trust in research done by the pharmaceutical industry. More recent work, yet to be published, shows that knowing that pharmaceutical industry research takes place in the NHS increases public trust. This provides an opportunity for pharmaceutical industry and the NHS to explain more about how they work together.

Over the last eighteen months—through a working group and workshops, and informed by opinion polling and public dialogue—the HRA has developed a public involvement strategy. The strategy sets out the approach of the HRA for involving patients and the public, and how it will use its influence to support the research community and NHS to involve patients and the public more in its work. The public involvement strategy has been well-received and supported by the working group, chaired by Simon Denegri (the NIHR's National Director for Public Participation and Engagement in Research and Chair of INVOLVE).[9]

The HRA's dialogue work shows patients and the public support the HRA's role in reducing bureaucracy and improving consistency in the research approval system. Patients in particular are keen to see more opportunities for people to take part in health research and believe that the HRA has a role in facilitating this. They were also supportive of the HRA's role in promoting the publication of research findings. Both patients and the public had confidence in the HRA's role in placing the well-being of patients at the core of its work.

Combined response for conclusions 11, 17, 19 and 20

Clinical trial transparency

11. Clinical trial transparency is important and greater transparency would be likely to provide a number of benefits, particularly if applied retrospectively. However, there are obstacles to achieving this and the drive for greater transparency must be balanced against other concerns, particularly the need to protect patient privacy. Greater disclosure does not necessarily equate to greater transparency if the information shared cannot easily be understood and we therefore recommend that efforts to increase the availability of clinical trial data focus on providing information that is accessible, assessable, intelligible and usable. (Paragraph 58)

[9] http://www.nihr.ac.uk/Pages/default.aspx

Level 2: Summary level trial results

17. We encourage academic publishers to remove "Ingelfinger" restrictions on the prepublication of summary-level results through media such as trial registries, in order to facilitate greater openness and faster access to important scientific data. (Paragraph 72)

Level 4: Individual patient-level data

19. We are not in favour of placing anonymised individual patient-level data (IPD) in the public domain in an unrestricted manner, as we consider that the risk to patient confidentiality is too great and, for many past and current trials, this level of disclosure would go beyond the confines of previously obtained patient consent. Nevertheless, we recognise the scientific value of IPD and consider these data to be currently underutilised. We agree with the Caldicott 2 Review that providing specific individuals with controlled access to personal confidential data such as IPD through carefully managed and secure "safe havens", together with contractual agreements about how that data can be used, is the best way forward. We also consider that access should be facilitated by an independent "gatekeeper", responsible for evaluating research proposals and ensuring that data is handled responsibly and in a way that makes a useful contribution to scientific knowledge. (Paragraph 88)

20. The UK could take the lead in shaping how a global system for sharing IPD for non-commercial trials might operate and a national system covering all non-commercial UK trials would be capable of delivering potentially significant benefits. We consider that the Health Research Authority (HRA) could act as developer, administrator and gatekeeper for a central repository of IPD for non-commercial UK trials. In order to achieve this, template consent forms provided by the HRA should allow for and emphasise to trial participants the benefits of data sharing. Research Ethics Committees should also take into account any transparency restrictions imposed by patient consent forms when evaluating research proposals for clinical trials. (Paragraph 89)

More information on our transparency agenda is below.

In relation to the "Ingelfinger" restrictions, we will in our engagement with publishers encourage the removal of this requirement to support our transparency agenda.

The HRA has a key role providing confidential advice on the use of patient confidential data for research and non-research purposes to the HRA and Secretary of State, under Section 251 of the NHS Act 2006 (which re-enacts Section 60 of the Health and Social Care Act 2001) and the Health Service (Control of Patient Information) Regulations 2002. Given this important contribution, it may be more appropriate for others, such as the Health and Social Care Information Centre to provide a central repository for IPD, in order to preserve public trust.

Dame Fiona Caldicott's review and the government response will help us take forward our work. This will also be informed by the work we are doing with Ipsos MORI to understand public views on accessing patient confidential data. Within the next month we will also be

asking stakeholders for examples of different approaches, to help us develop guidance on best practice strategies for identifying patients to participate in health research.

The HRA will issue guidance on consent and participant information sheets for use and comment on 4 October 2013. We will incorporate the point about data sharing when the guidance is reviewed and fully support that our guidance and the Research Ethics Committee review should ensure there are not later barriers to transparency because the issues were not considered at the point of consent.

Current initiatives to increase clinical trial transparency

27. We agree with the Joint Committee that the Care and Support Bill should make the promotion of research transparency a statutory objective of the HRA and we recommend that the Government includes the necessary provision. (Paragraph 109)

We fully committed to the transparency agenda and for our role in promoting transparency.

28. Research Ethics Committees should have a role in considering and monitoring compliance with transparency policies. As such, we welcome the HRA's new transparency policy and support, in principle, the proposals made in its May 2013 paper. We recommend that the HRA initially retains full responsibility for policing its own policies and ensures that all trials have been registered and published according to an agreed timeline, rather than performing checks on a sample basis. In addition, there must be penalties for non-compliance. We recommend that the HRA provides us with a progress update on implementation of its new transparency policy by the end of 2013. (Paragraph 110)

The HRA announced on 16 July 2013 that its action plan for increasing transparency was being implemented. Last month, we announced the implementation of the first of a series of measures to improve transparency:[10] from 30 September 2013, registration of clinical trials in a publicly accessible database will be a condition of the favourable ethical opinion given by Research Ethics Committees. We have also committed to a review of the applicant declaration to RECs so that when new applications are made we seek formal assurances that previous studies have been registered and findings put in the public domain. We have stated that we expect all studies to be registered and published.

The HRA believes fundamentally in providing important reassurances to the public on the issue of research transparency. We will, in addition to trial registration:

- Work with partners to understand what is meant by publication and to make sure that where research is undertaken, it is subsequently published according to plans agreed with the REC at the time of approval
- Undertake an audit of completed studies to more fully understand publication and registration rates in the UK

[10] http://www.hra.nhs.uk/

- Look for further ways to monitor compliance to publish within the agreed conditions of REC approval
- Explore means by which researchers, sponsors and funders will demonstrate good conduct.

A BMJ Editorial on the HRA's transparency agenda has recently been published: Health Research Authority's great leap forward on UK trial registration, Iain Chalmers, BMJ 2013;347:f5776 (Published 25 September 2013).[11]

We will continue to publish updates on the implementation of our transparency agenda on the HRA website.

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[11] http://www.bmj.com/content/347/bmj.f5776

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